Prevention in Arizona: A Strategic Guide

Arizona Department of Health Services/
Division of Behavioral Health Services

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FOREWORD

The 2012 Theoretical Framework for Prevention in Arizona is a revision of the 2005 Framework for Prevention in Behavioral Health. The purpose of this 2012 revision is to establish key directions for Division of Behavioral Health Services prevention programs for the years 2012 through 2015 and establish clear guidelines, expectations and contract obligations for Tribal and Regional Behavioral Health Authorities (T/RBHAs), their subcontracted prevention providers, and Tribal Contractors.

To promote the health and wellness of the Arizona communities and residents, ADHS is committed to a collaborative approach in planning and implementation of interventions designed to prevent the onset of behavioral health disorders. The goal of the ADHS is to ensure a comprehensive, unified behavioral health care system for all Arizonans.

ADHS is honored to be an active member of the Arizona Substance Abuse Partnership. Success in reducing substance abuse in Arizona may only be realized through a comprehensive and cooperative effort led by a thorough assessment of substance abuse issues and conditions which contribute to their onset followed by careful, cross system strategic planning. This involves the collaboration between state agencies in developing comprehensive strategic plans that streamline the combined efforts of prevention, treatment, and law enforcement.

Arizona has made tremendous progress in the prevention of behavioral health disorders and has experienced drastic reductions in substance abuse since 2002. ADHS will strive to improve the efficiency of preventative efforts in Arizona through application of evidence based practices inclusive of innovative and culturally based interventions.

This document will be reviewed and updated frequently in collaboration with the ADHS policy office.

I. THE ADHS/DBHS PREVENTION SYSTEM

The Arizona Department of Health Services (ADHS) is the State agency responsible for promoting the physical and behavioral health of all Arizonans. The ADHS is home to the Division of Behavioral Health Services (DBHS), which serves as the single state agency to provide coordination, planning, administration, regulation and monitoring of the state public behavioral health system. DBHS has primary responsibility for administering a system of behavioral health care, which is responsive, individualized, compassionate, culturally sensitive, and equally accessible. The comprehensive array of services is culturally and community based, family focused, and complements and fosters the strengths of individuals and communities.

DBHS is responsible for administering a full continuum of behavioral health services. DBHS contracts with Tribal and Regional Behavioral Health Authorities (T/RBHAs) and Tribal Contractors to administer behavioral health services in the State. Regional Behavioral Health Authorities (RBHAs) are private, non-profit and for profit managed care organizations, subcontracted by ADHS. Their role is to administer a full range of behavioral health services in their contracted region under the guidance and direction of DBHS.

Behavioral Health services are provided for people who reside in their geographic service area. Arizona is divided into six geographic service areas (GSAs). GSA one consists of Coconino, Navajo, Apache, Yavapai, and Mohave Counties. GSA two includes La Paz and Yuma Counties. GSA three is composed of Graham, Greenlee, Cochise, and Santa Cruz Counties. GSA four is comprised of Pinal and Gila Counties. GSA five is Pima County and GSA six is Maricopa County.

T/RBHAs administer the behavioral health service delivery network regionally, including contracting and payment for various behavioral health care and prevention services to children, adults with serious mental illness, adults with substance abuse/dependence and general mental health disorders. They are also responsible for monitoring and improving the effectiveness of services. Prevention is an essential part of this system, dedicated to decreasing the incidence of behavioral health problems.

ADHS has Intergovernmental Agreements (IGAs) with several Arizona Tribes to provide behavioral health services for Native Americans on reservations. Each Nation with an IGA for behavioral health services is responsible for implementing prevention services in accordance with this framework.

1. WHAT IS PREVENTION?

Prevention programs funded through DBHS decrease the prevalence and severity of behavioral health problems among populations that do not have a diagnosable behavioral health disorder. Prevention is accomplished by developing the strengths of individuals, families, and communities.

DBHS refers to the Arizona Revised Statutes (ARS) 8-201.23 and Federal Regulations to define prevention. The ARS define prevention as "the creation of conditions, opportunities, and experiences that encourage and develop healthy, self-sufficient children and that occur before the onset of problems" (Arizona State Legislature, 2007). The ARS definition refers only to children because it is located in the children's statutes. Although the ARS definition speaks for many programs, it does not accurately describe *all* of Arizona's prevention programs, particularly those that serve adults. For this reason, DBHS also uses the broader definition of prevention provided by Federal Regulations that creates the block grant dedicated to states for substance abuse prevention. This definition states that "primary prevention programs are those directed at individuals who have not been determined to require treatment" (Electronic Code Federal Regulations, 2009).

2. The Continuum Between Prevention and Treatment

Prevention is part of a continuum of behavioral health services that includes treatment and recovery support. This continuum of services strives to accomplish the same goals of healthy individuals, families, and communities. In Arizona's behavioral health system, prevention, treatment, and recovery support providers often use similar strategies to achieve their respective ends. The main difference is the targeted population, collaboration process and method of implementation. Prevention targets people who do not have a diagnosable behavioral health problem and who are not enrolled in the behavioral health system. Treatment targets persons with diagnosable behavioral health disorders of sufficient severity to require symptom-focused services and recovery supports. Individuals in the treatment system are assessed and enrolled in the behavioral health system. Both the prevention and treatment systems provide education about topics related to wellness, such as communication skills and stress management, and thus are invested in collaboration. However, the implementation and targeted audience differs between prevention and treatment.

A. Collaboration

In treatment, the collaborative process is often referred to as Child and Family Teams or Adult Clinical Teams. The teams are a group of people that includes, at a minimum: the behavioral health recipient, his/her family, any caregiver, a behavioral health representative, and any individuals important in the behavioral health recipient's life and who are identified and invited to participate. This may include, for example, teachers, extended family members, friends and other natural supports, family support partners, healthcare providers, coaches,

community resource providers, representatives from religious communities, and agents from other service systems such as Child Protective Services or the Division of Developmental Disabilities. The size, scope and intensity of involvement of the team members are determined by the objectives established for the child or adult consumer. They are also dependent upon which individuals are needed to develop and coordinate an effective service plan. For this reason, the collaborative team can expand or contract as necessary to be most helpful to the behavioral health recipient.

In prevention, the collaborative process is called community-based process or community development. Community development is a strategy whereby key stakeholders in a community (including families, youth, schools, behavioral health specialists, etc.) come together to assess community needs and then collaboratively plan and implement prevention activities.

Environmentally focused and community-wide strategies are utilized to change conditions for the entire population. Prevention programs aid communities and families in developing and implementing high-quality and low-cost answers to their problems. Through environmental strategies for prevention that are targeted at the entire population, everyone has an opportunity to benefit, ultimately decreasing the costs to the State.

Prevention programs change conditions to promote the health of communities. However, the most effective approaches recognize and build upon the power of the community to bring out the best in its citizens. Underlying prevention efforts is the belief in the innate resilience of people and in the community's capacity to address its own needs. Prevention in behavioral health is a fluid, dynamic approach to helping communities meet the ever changing needs of their citizens and creating conditions that support healthy people, families, and communities.

B. Target population

Treatment works with individuals and families who have already developed behavioral health problems and works to restore them to good health. As part of the same continuum of services, prevention and treatment work together to ensure that people who need behavioral health treatment receive those services. When prevention professionals encounter individuals and families who need more intervention, they are referred to treatment services.

Prevention works with entire communities, schools, and other systems to establish conditions that support the development and maintenance of healthy behavior. While individuals and families are part of those efforts, the goals and strategies target entire towns, ethnic/cultural communities, tribes, schools, counties, school districts, senior centers or classrooms to change the conditions in those systems to affect the behavioral health of large numbers of individuals in each system.

3. Prevention Funding

Funding for prevention in the Division of Behavioral Health Services (DBHS) comes from the Federal Substance Abuse Prevention and Treatment Block Grant (SAPT). The DBHS is responsible for the annual development and submission of the Substance Abuse Block Grant to the United States Substance Abuse and Mental Health Services Administration (SAMHSA). SAPT contains the annual allocation from Congress of federal funds to support substance abuse prevention, intervention and treatment services in the 50 states and 10 U.S. territories. Twenty percent of block grant monies are used to fund substance abuse prevention programs.

4. Managed Care in Arizona

DBHS strives to create a seamless continuum of behavioral health services to meet the needs and promote the health of Arizonans using the most cost effective strategies available with emphasis on the empowerment of communities. A comprehensive, evidence based system of prevention services reduces costs for treatment services by delaying the onset, decreasing the prevalence, and reducing the severity of behavioral health problems. Prevention reduces the number of enrolled members for T/RBHAs, and helps communities and families develop and implement meaningful, sustainable and low-cost solutions.

Managed care organizations invest in the health of communities to reduce the costs associated with substance abuse and other risk factors. Table 1, below, lists the primary objectives in managed care. The success of each Tribal and Regional Behavioral Health Authority (T/RBHA) is inherently tied to the health and well-being of the population living within its GSA or community. Prevention is the most cost-effective way to maximize the health and well-being of communities. The integration of prevention services to the behavioral health system is essential in reducing risk factors associated with specific disorders. For every $1 spent on prevention, communities can save $4 to $5 dollars in cost for drug abuse treatment and counseling (Pentz, 1999).

Table 1
Prevention objectives in managed care

1. Reduce the incidence and prevalence of behavioral health disorders in the population.
2. Reduce demand and need for expensive and intensive treatment services.
3. Improve individual and family functioning through specific skill building strategies.
4. Mitigate community, environmental, and other conditions, which are precursors to behavioral health disorders.
5. Promote the health and well being of communities and community members.

5. Ethics

When a prevention professional has knowledge of unethical conduct or practice on the part of an agency or prevention specialist, he or she has an ethical responsibility to report the conduct or practices to appropriate funding or regulatory bodies or to the public. There will be no reprisal against the prevention specialist from the disputed agency or prevention specialist that is reported.

Self care

Each prevention professional adheres to non-use of illicit substances. Each prevention professional should be willing to seek appropriate behavioral health care for him- or herself as needed to ensure his or her health.

Confidentiality

Confidential information acquired during service delivery shall be safeguarded from disclosure, including – but not limited to – verbal disclosure, unsecured maintenance of records, or recording of an activity or presentation without appropriate releases. Prevention professionals are responsible for knowing the confidentiality regulations relevant to their organization.

Professionalism

Each prevention professional should perform all responsibilities with the highest sense of integrity. All information should be presented fairly and accurately. Each professional should document and assign credit to all contributing sources used in published material or public statements. This includes truthfully and accurately representing one's own actions and decisions. Prevention professionals are not to be associated directly or indirectly with any service, products, individuals, and organizations in a way that is misleading. This may include, but is not limited to: expending prevention funds to offset financial losses in other areas, offering or accepting bribes, expending prevention funds for non-prevention related expenses.

Prevention professionals must maintain professional boundaries with program participants.

Prevention professionals shall strive continually to improve their personal competence and quality of service delivery. The maintenance of competence requires a commitment to learning and professional improvement that must continue throughout the career. Each prevention professional should recognize his or her own limitations and boundaries and not use techniques or offer services (such as therapy) in which he or she is not competent. Each professional is responsible for assessing the adequacy of his or her own competence.

II THEORY OF STRATEGIC PREVENTION FRAMEWORK

Arizona uses the Strategic Prevention Framework (SPF) established by the Substance Abuse and Mental Health Services Administration (SAMHSA). This five-step planning process guides the work of States in their prevention activities. In Arizona, the SPF is used to to inform the selection, implementation, and evaluation of culturally appropriate and sustainable prevention activities. The SPF model is preferred because it promotes fluidity, enabling prevention strategies to adapt to changing intervening variables and community norms related to substance abuse. The five steps of the SPF are guided by the principals of cultural competence and sustainability, and they are as follows:

1. Assessment
2. Capacity
3. Planning
4. Implementation
5. Evaluation

Figure 1:
Strategic Prevention Framework

1. Assessment

Assessing the community's needs and resources is an essential step in community change. An assessment is performed to discover levels of substance abuse, related consequences, and causal factors as well as a community's current resources for making change. An effective assessment helps the community be sufficiently informed to identify its greatest needs and prioritize which problems should be targeted first.

A community needs and resource assessment is a process by which information is gathered about conditions within a community and used to develop prevention programs. Community needs and resource assessments are conducted by providers and T/RBHAs for the purpose of developing programs which meet the needs of communities, geographic service areas, and the state. A key resource for data collection during the assessment process is the Arizona Department of Health Services, which is an active participant in the State Epidemiology Work Group and has led the way in gathering and preparing invaluable data identifying the State's primary substance use problems. This group is a collaboration between numerous state-wide

entities concerned with elimination of substance abuse in Arizona. The Work Group publishes the Substance Abuse Epidemiology Profile in Arizona every two years. This profile serves as the needs assessment for the state of Arizona and all state level departments. T/RBHAs, providers, and coalitions also conduct assessments of need at minimum once every three years, using the state epidemiological profile as a guide to ensure a uniform assessment process.

One of the goals of the needs and resources assessment is to inform the selection of a target population (the group of people for whom a prevention program is designed) and develop program goals and objectives. Target populations are selected by considering which populations have the greatest need (as indicated by high prevalence of risk factors and low prevalence of protective factors) and comparing that to resources available to that population (existing programs, grants, other agencies). Some things to identify when doing a needs and resources assessment are community resources, community readiness, and risk/protective factors.

A. Community resources

It is important to identify the assets and resources already available in each community so that gaps in services can be filled and capacity developed to meet needs. A resource assessment includes identification of all stakeholders in substance abuse, treatment, prevention, and enforcement, as well as financial resources and capacity.

B. Community readiness

A community readiness assessment determines the degree to which the community is prepared to move forward in changing the targeted factors that attribute to the substance abuse problem. Prevention efforts should be strategically designed to meet communities at their own level.

C. Intervening variables

The chance that an individual will develop behavioral health problems is influenced by the interactions between multiple biological, psychological, and social factors. By measuring risk and protective factors in a population, also known as intervening variables, prevention programs can be designed to reduce elevated risk factors and increase protective factors.

Some risk factors cannot be changed by a prevention program, such as history of problem behavior, temperament, and transitions. The identification of these risk factors helps target populations who are vulnerable to developing substance abuse or other behavioral health problems. Other risk factors, however, are easily changed by a prevention program, such as low expectations, peer pressure, and social failure. These factors are used to establish prevention program objectives.

Prevention programs focus on enhancing protective factors for the purpose of preventing and/or delaying the onset of substance abuse and other mental health conditions. Table 2

summarizes intervening variables grouped into five domains: community, family, institutional, individual, and peer and relationship.

Table 2:
Protective and risk factors

Domain	Protective Factors	Risk Factors
Community	Access to community resources Opportunities for meaningful participation and service	Socio- economic deprivation Discrimination and devaluation Community disorganization Availability of ATODs
Family	Secure attachment Authoritative discipline Family involvement Caregiver monitoring Belonging Family support Traditional cultural values	Low family attachment/ bonding Family conflict and violence Parental absence Family management problems Abuse, neglect, or rejection Caregiver behavioral health problems Family attitudes favor substance use
Institutional (School, Work, Senior Care Home, Faith Based Organization)	Opportunities for involvement Opportunities for success Strengths focused Challenge with support Caring, supportive relationships Cooperative learning Safety	Lack of opportunities for social interaction Poor discipline Low expectations Lack of comfort
Individual	Temperament Empathy School success Intelligence Self-efficacy Problem solving skills Good coping skills Social competence Cultural pride Autonomy Physical health School connectedness Religion /spirituality Sense of purpose/future	Genetic factors and temperament History of behavioral problems Impulsiveness and rebelliousness Poor self esteem Anti-social attitudes, beliefs, behaviors Low commitment to school Poor coping skills Changes in health, chronic illness, pain Perceived harm Early use of substances Academic problems Transitions Prenatal exposure to ATOD Belief in traditional gender roles
Peer and Relationship	Bonding to a positive adult Bonding to positive peers	Loss of relationship Social failure Perceived isolation Friends/ partners who use substances or engage in other problem behavior

Needs and resource assessments can be conducted using a number of methods such as the gathering of social indicator data, key informant interviews, focus groups, surveys, and/or public forums. During the needs assessment process, community members are addressed as resources that inform the development of the program.

D. Social indicators

Social indicators measure the prevalence of protective and risk factors and social problems based on archival data from records collected and kept by agencies. Indicators establish an overall picture of trends related to substance abuse and suicide within a specified geographic area. An assessment using social indicators consists of gathering data and/or vital statistics about community, county or state conditions such as crime rates, rates of adolescent pregnancy, deaths due to substance abuse, maternal use of alcohol or other drugs during pregnancy, etc. RBHAs use social indicator data including AHCCCS eligibility rates and utilization data to target communities and populations for prevention programs. Social indicator data can be gathered from web sites, government publications, organizational databases, and formal surveys conducted by organizations. Social indicators are often referred to as archival data on some web sites.

E. Key informants

Key informant interviews are a key component to establishing a culturally based prevention program. The community needs and resource assessment should take community members and cultural resources into account (i.e. local non-traditional and traditional healers and teachers) and should be informed by cultural experts or informants/insiders from the respective community. Gathering this type of supplemental data is recommended.

F. Focus groups

A focus group is an interview with a small group of people who have common characteristics. Group members should be representative of the target population, and/or considered experts regarding the target group. The group is interviewed using a standard set of questions about their perceptions of conditions, needs, and resources in the community. Gathering this type of supplemental data is also recommended.

G. Surveys

Providers are discouraged from creating their own surveys for needs and resources assessment and are encouraged to use data from existing surveys such as Arizona Youth Survey, Behavioral Risk Factor Surveillance Survey, and Youth Risk Behavior Survey.

H. Public forums

Another form of assessment is the public forum. A public forum is a meeting where

community members who are insiders, cultural experts and/or delegates provide their opinions about community needs and resources. Another term for public forum is town hall. Gathering this type of supplemental data is recommended.

2. Capacity

T/RBHAs provide training and technical assistance for providers and regional stakeholders to develop skills and minimum competencies for successful implementation of the prevention initiatives. Prevention professionals must be supervised and coached by a supportive administration.

The internal capacity of providers and coalitions as well as community readiness must be developed to effectively address the primary causal factors/intervening variables that contribute to substance abuse within a community. This requires collaboration between multiple sectors to effectively target all of the prioritized causal factors. In assessing community readiness it is important to consider what ground work needs to be laid before the implementation of a strategic plan. Initiatives that can experience quick successes may be necessary in order to initially mobilize a community around its primary substance abuse problems. Early successes from smaller projects or events help to build relationships and trust within targeted communities, attracting key stakeholders to participate in coalition efforts.

In order for a community to develop and implement a successful strategic plan, training and technical assistance must be provided throughout each step of the strategic prevention framework. Coalition members should receive continual training on community prevention program development at conferences like the Community Anti-Drug Coalitions of America (CADCA). Community stakeholders should be mobilized and empowered to take leadership roles in coalition development. The continual assessment of the need to build capacity in response to a community's substance abuse problem ensures effective and sustainable prevention efforts.

A list of possible web-based resources for providers/coalitions to access in developing prevention workforce capacity may be found on the ADHS/DBHS Office of Prevention web page: http://www.azdhs.gov/bhs/ops.htm.

3. Planning

The planning phase involves the creation of a comprehensive plan with goals, objectives, and strategies aimed at both the individual and environmental level, in response to the primary substance abuse problem and related consequences faced by a community. An effective strategic plan is based on documented needs and builds on community resources and strengths. The plan establishes broad goals with measurable objectives that strategically address the causal factors attributing to the substance use problem. It also identifies how progress will be

monitored and evaluated in order to continually make strategic developments throughout each step of the Strategic Prevention Framework process.

A. Strategies

Strategies are specific, research-based approaches for achieving project objectives. The overall strategic plan should identify *all* strategies required to reach the goals and objectives of each program.

Strategies should directly address the underlying risk and protective factors of the target population or geographic area that contribute to the substance abuse problem and consequence in a community. Coalitions and providers should elect multiple strategies that are linked to the prioritized intervening variables and work within different domains. Both internal capacity and community resources need to be developed in the selection and implementation of strategies. It is important to assess the logic behind the assumption of how a strategy will work by explaining how its activities will result in the anticipated change in the underlying conditions contributing to the substance abuse problem.

Table 3:
Division of Behavioral Health Prevention Strategies

CSAP Strategy	Corresponding DBHS Prevention Strategy	Description
Problem Identification and Referral	Problem Identification and Referral	This strategy involves identification of persons who have signs of a behavioral health disorder and may need a referral for further assessment.
Education* **Written curricula need to be used.*	Training and community education	Training provided to behavioral health professionals, school staff, volunteers, medical professionals, home care staff, community groups and others to enhance knowledge or skills related to substance abuse, suicide, and/or working with youth, families, aging populations, or communities.
	Family Support and Education	Ongoing, sequential, educational sessions targeted to parents, family members and/or caretakers of children, persons with disabilities, or seniors.
	Life Skills Development	Ongoing, long-term educational activities that develop or improve life skills such as decision making, coping with stress, problem solving, conflict resolution, and/or resistance skills.
Public Information	Public Information and Social Marketing	Presentation of accurate messages and promotional material on substance abuse, suicide, child rearing, care giving and other behavioral health issues. May include health fairs, development and distribution of electronic or print media, public service announcements and other related methods.

Alternatives	Personal and Cultural Development	Activities that provide challenging and positive growth experiences and opportunities to practice skills learned in a natural environment. Includes cultural ceremonies, art, camping, ropes courses, team building activities, etc. This strategy must be used in combination with other strategies. It should not be used in isolation.
	Mentorship	Activities in which positive role models provide support and guidance to assist individuals in achieving personal growth.
	Peer Leadership	Activities that reinforce leadership capabilities of participants and develop skills, peer facilitation of education workshops, and community service learning.
Community Based Process	Community Based Process	Development of a grassroots movement to address community protective and risk factors related to behavioral health. Includes establishment and maintenance of collaborative relationships with key stakeholders. Activities target entire populations.
Environmental	Environmental Strategies	Involvement in coalitions/community groups which explore ways to enact policies that will create environmental change.

B. Evidence-based strategies

Evidence-based strategies must be in accordance with guidelines developed by SAMHSA/ CSAP (2009). These guidelines stipulate that an evidence-based program is one which meets one of the following requirements:

- Included on a Federal list or registries of evidence based interventions
- Reported (with positive effects) in peer reviewed journals
- Documented evidence of effectiveness supported by other sources of information and the consensus judgment of informed experts.

C. Direct and indirect strategies

Direct prevention strategies generally use existing social mechanisms to reach individuals and others at risk, such as youth leaders, seniors, indigenous populations, teachers, and new parents. These approaches focus on helping people develop the knowledge, attitudes, and skills they need to change their behavior.

Indirect prevention strategies focus on norms, regulations, and availability. These approaches focus on creating an environment that makes it easier for people to act in healthy ways, so they are also known as environmental strategies. To employ an indirect strategy, it is necessary to work closely with a broad set of community systems, such as:

- Media (newspapers, radio, and television)
- Legal systems (e.g., local police, the judicial system, the legislative system)
- Community-based organizations, businesses, religious groups

Indirect or environmental strategies are not intended to replace prevention efforts targeted at individuals. Rather, they are most effective when used in conjunction with individual

interventions. The idea of combining **environmental** strategies with efforts to change individuals' knowledge, attitudes, values, self-concept, and self-esteem is sometimes called the "**social ecological**" model of prevention.

Without the backup of indirect strategies, programs employing direct strategies and targeting individuals may find their effectiveness undercut by external pressures. For example, youth who have been taught the "life skills" to resist negative influences are better served if society also addresses the glamorization of alcohol use, the accessibility and acceptance of underage drinking, and the shortage of effective penalties for violators.

D. Population selection and the IOM model

The Institute Of Medicine (IOM) model describes three types of populations a prevention program might target: universal, selective, and indicated. A universal prevention program targets the entire population regardless of degree of risk for developing a behavioral health problem. A selected prevention program targets persons with specific risk factors. Indicated prevention programs target persons at high risk for behavioral health problems, but who do not have a diagnosable behavioral health problem.

Table 4:
Universal, selected, and indicated prevention programs

Type of Program	Description
Universal Indirect	Interventions which support population-based programs and environmental strategies (e.g. establishing ATOD policies, modifying ATOD advertising practices). This includes interventions involving programs and policies implemented by coalitions.
Universal Direct	Interventions which directly serve an identifiable group of participants who have not been identified on the basis of individual risk (e.g. school curriculum, after-school program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g. coalitions).
Selective	Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
Indicated	Activities targeted to individuals identified as having minimal but detectable signs or symptoms foreshadowing disorder, or individuals who have biological markers indicating predisposition for disorder but not yet meeting diagnostic levels.

Note: From Western Centers for Applied Prevention Technology, 2008.

E. Logic model

An outcome-based logic model outlines the theory behind the plan to achieve community-based change. It maps out the primary substance abuse related consequences and trends. It also identifies the intervening variables (risk/protective factors or causal factors) that have been

scientifically proven to contribute to the problem, as well as the prevention strategies specific to the targeted contributing factors and population. A logic model is used to set goals and objectives and assess if they are achieved through process and outcome evaluations. Table 4 summarizes the factors of an outcome-based logic model, which are further explained below.

Table 5:
Outcome-based logic model

Substance Use Related Consequences	Substance Use Trends	Goals	Intervening Variables	Objectives	Strategies
The primary problems identified in community assessment	The related substance use behavior identified in community assessment	The ultimate desired outcomes of efforts targeting prioritized intervening variables	The prioritized risk and protective factors to be addressed identified in community assessment	The concrete statements outlining desired changes in contributing factors	The approaches that will address the intervening variables/ contributing factors

Substance use and related consequence

The first step in forming a logic model is to establish the primary substance use problem and related public health consequences. Problems are selected based on clear data patterns indicating the primary substance abuse problem in a community. The primary problem may also be specified by community members at community town halls and may even be indicated by the media coverage of a problem in the community. Alcohol, tobacco and other drug (ATOD) consumption and consequence data should be assessed to identify the prevalence of substance use and the severity of the related consequences. The problems faced by a community should be continually assessed through recent data, informing the ongoing process of program planning and implementation.

Intervening variables (also called risk/protective factors or causal factors)

The next step in developing a logic model is to prioritize intervening variables, or risk/protective factors, that influence the substance abuse problem and related consequences. Research literature should be used to determine severity, which shows the variables that have the greatest community impact on the substance abuse issue identified. Prioritization of intervening variables should be based not only on the severity of substance abuse consequences, but also on the capacity and readiness of the community to respond to the problem. During the needs assessment, the internal capacity of a program or coalition is assessed to determine whether or not there is the capability to begin implementing a strategy. Even when there is severe need, a lack of capacity needs to be addressed before efforts to

implement a plan begin. The assessment of community readiness helps to determine what initial work needs to be done to mobilize the community around an identified problem.

It is necessary to first collaborate with different sectors and key stakeholders of the community in order to target all of the intervening variables related to their primary substance use problem. In developing a comprehensive strategic plan, a variety of strategies are selected, which target different variables within multiple domains, thus increasing the effectiveness of prevention efforts.

Goals and objectives

In the next step of developing a logic model, goals and objectives are selected for each intervening variable. A goal statement establishes the broad desired change and prioritized intervening variables towards which efforts are directed. The goal statement should reflect the perceived present and future need for specific prevention strategies which aim at realistic outcomes. An example of a goal statement for the intervening variable of *easy social acces*s contributing to the substance use problem of underage drinking would be: "to decrease availability of alcohol through social sources among adolescents under the age of 21. "

Objectives are specific statements, which measure immediate change in the targeted contributed factors. They describe the element of contributing factors that will be measured, the desired amount of change, and the time frame in which the change will happen. For example, a contributing factor to underage drinking might be that young adult peers who provide alcohol to minors have favorable attitudes of underage drinking. A subsequent objective could be "to increase the perception of harm or decrease favorable attitudes toward underage drinking amongst adult peers by May 1, 2009".

It is important to measure the achievement of objectives, whether short-, medium- or long-term, by tracking the change in contributing factors through pre- and post-measurements. Changes in identified intervening variables strategically influence the desired change in a community's level of substance use and related consequences.

The "best fit" program/ strategy option

The final step in developing a logic model involves selecting effective strategies which target the identified contributing factors. It is important to perform a literature review on evidence-based practices, policies, or programs that have been proven to successfully address the targeted contributing factors. Strategies should be specific to the focus population and incorporate community feedback in order to ensure that they are culturally appropriate. There should be a logical connection between a selected strategy and the intervening variables/ contributing factors that they hope to change. Use "if-then" statements to assess why and how the program's activities lead to changes in intervening variables.

An action plan translates a logic model into action by detailing the key tasks that must be completed. For example, an action plan for the strategy "media campaign around the danger of

underage drinking" would outline who is responsible for implementing what activities, when and where they will be accomplished, and towards whom they will be directed. The action plan provides the template for continually monitoring and evaluating the effectiveness of a strategy. This ensures that successful strategies can be replicated and sustained within a community. Table 5 is an example of what an outcome-based logic model to reduce alcohol use among youth under the age of 21 could look like.

Table 6:
Logic model example

Substance Use Related Consequences	Substance Use Trends	Goals	Prioritized Intervening Variables	Objectives	Strategies
High rate of alcohol-related crash fatalities among 15-21 year olds	50% of youth (under the age of 21) used alcohol in past 30 days	To reduce alcohol use among youth under 21	Easy social/ retail access to alcohol for youth	To decrease access to alcohol by increasing monitoring of retailers who sell alcohol.	Compliance checks for retailers selling alcohol
	25% of youth participated in binge drinking in past 30 days		Low perceived risk of alcohol use among youth	By October 2012, increase perceived risk of alcohol use among youth by a statistically significant amount as measured by surveys.	School based training on harmfulness of alcohol use
			Social norms accepting/ promoting youth alcohol use	To decrease social acceptance of youth alcohol use by a statistically significant amount by 2013.	Media advocacy to increase concerns about youth alcohol use

4. Implementation

After assessing the community's primary substance abuse problems, building capacity around those problems and developing a comprehensive strategic plan, communities can successfully implement prevention programs that fit the needs of the community and match the population served. Throughout the SPF process it is vital that each step is continually assessed to consider the need for making adaptations while maintaining program fidelity to accomplish its original goal.

A major appeal of evidence-based programs and practices is their promise of effectiveness. Through rigorous evaluations, such programs have shown that they can significantly affect important outcomes for participants and communities. However, a program or practice will only continue to have those effects if it is implemented according to the original program design. Staying true to the original program design is referred to as program fidelity. True program fidelity is not easily achieved in practice. Practitioners often change or adapt evidence based programs and practices as they implement them: sometimes intentionally and other times not.

One of the most difficult challenges to effective substance abuse prevention is finding the right balance between maintaining the fidelity of a model prevention program or strategy and adapting to reflect the circumstances of the community where it is being implemented. It is imperative that attention be given to both fidelity and adaptation during the complex process of program implementation. One of the key steps for finding balance between program fidelity and adaptation is ensuring that those who are collaborating on the program's implementation share the definition of fidelity and adaptation.

A. Considerations for Maintaining Fidelity

Fidelity is part of quality assurance and is thought of as the implementers' ability to keep the 'signature' of the program, policy or practice. It is only achieved when implementation of an intervention adheres to the core elements and internal logic that made the original intervention effective. If an intervention is implemented or adapted without fidelity to these components, the likelihood that prevention providers will have program outcomes that are similar to those in the original research is decreased.

For this reason, providers are foremost encouraged to ensure that the selected program or practice fits the causal factors or intervening variables that contribute to the identified problem being addressed. Likewise, an alignment of capacity, resources, and readiness of the community and its participating organizations is critical to program selection as are the results of the local needs and resources assessment. By selecting a program that meets the needs of the target population/community, fewer changes are needed and it is more likely to have the desired effect on participants and the community.

Even after careful consideration and alignment of programs or strategies to address the population or community needs, adaptations may become necessary to ensure relevance in local settings or with new populations. Before any adaptations are made, program developers and implementers must identify the causal model for how change takes place as a result of the intervention (i.e. why the program works). This step is critical in determining what necessary adaptations will not alter the core components of the program. Core components should not be ignored, added to, or changed. Below are a set of six guidelines from the Center for Substance Abuse Prevention (CSAP) for balancing program fidelity and adaptation.

1. **Identify and understand the theory base behind the program.**
   Published literature on the program should provide a description of its theoretical foundation; if not, an inquiry to the program developer may yield this information.

   This may or may not include a logic model that describes in linear fashion how the program works. The theory and logic model are not in themselves the core components of a program, but they can help identify what core components are and how to measure them. This step also identifies core values or assumptions about the program that can be used to help persuade community stakeholders of the program's fit and importance for their environment.

2. **Locate or conduct a core components analysis of the program.**
   This involves identifying the major components of a program, including: component description, type (universal/selected/indicated), domain, target information (age, race/ethnicity, gender, other), and purpose. This will provide implementers with a roster of the main "program ingredients," and at least a sense of which components are essential to likely success and which are more amenable to modification, given local conditions. In essence, core components analysis represents a bridge between developer and implementer, and between fidelity and adaptation. Ideally, the program developer or a third party will have already conducted the core components analysis. If not, with good information about the program, an implementer can at least approximate this informally (Education Developer Center Inc., 2003). http://captus.samhsa.gov/western/resources/pdf/fidelity_adaptation_toolkit_final_withcover.pdf).

3. **Assess fidelity/adaptation concerns for the particular implementation site.**
   Determine what kinds of adaptations may be necessary, given the target population and community environment. Identify core components which are especially critical to fidelity.

4. **Consult as needed with the program developer to review the above steps and how they may have shaped a plan for implementing the program in a particular setting.**
   This may also include actual technical assistance from the developer or referral to peers who have implemented the program in similar settings.

5. **Consult with the community where the implementation will take place.**
   This is a process to obtain input on how to do the implementation successfully, as well as build support for the program.

6. **Develop an overall implementation plan based on these inputs.**
   Include a strategy for achieving and measuring fidelity/adaptation balance for the program to be implemented, both at the initial implementation and over time. By addressing all of the complex stages of implementation, such a plan can increase the opportunities for making choices that shape a program, while maintaining good fidelity.

B. Considerations for making adaptations

When it is determined that adaptations are necessary to a program or strategy in order to reflect the circumstances of the community where it is begin implemented, the implementer modifies key characteristics, activities or delivery methods without eliminating or contradicting core elements of the intervention. When deciding whether or not a selected evidence-based program or practice may require adaptation, it is important to consider the utility and feasibility of the change or innovation being considered. Critical questions must be asked, such as whether the intervention has been implemented successfully with the same or similar population or if differences between populations are likely to compromise results.

For many years, there was a debate in the scientific literature over whether adaptation of evidence-based programs was acceptable. In recent years, the focus has turned more to which approaches to program adaptation are acceptable and which types are likely to undermine effectiveness.

In summary, taking program or practice selection seriously, being thoughtful about what (if anything) you change, and adding appropriate components or topics that are needed will help avoid changing the core components of the program and diluting its effectiveness (Martinez, 2004, Cooney, 2007, Backer, 2003).

5. Evaluation

Ongoing monitoring and evaluation are essential to determine if goals have been met and the desired outcomes achieved. Evaluation is essential to the assessment of program effectiveness and quality of program implementation. It helps to identify areas of needed improvement and promote the sustainability of effective policies, programs, and practices.

Program evaluation is a tool prevention professionals use to learn about program strengths and weaknesses and to make adjustments to improve the quality of services provided. Program evaluations should measure both processes and outcomes. Practical evaluations provide feedback that encourages programs and communities to augment their efforts where successful and to modify or abandon unsuccessful efforts.

Outcome evaluations measure changes in participant perceptions, attitudes, knowledge, behaviors, and risk or protective factors. Outcome evaluation uses core evaluation instruments, which are a set of common evaluation tools used by programs in Arizona and across the United States.

A. Process

Process evaluation assesses whether the program was implemented as planned and with quality. The process evaluation is descriptive. It provides information about the people served by the program and documents program activities, materials, and staffing. It also provides information on milestones reached during implementation; monitors scheduling and quality; tracks program costs; and creates a descriptive base for program replication. Process evaluation enables comparisons between the program plan and its actual implementation, and offers opportunities to adjust and refine the program as needed along the way.

The following is a list of what process evaluations provide:

- Information about participants
- Documentation of program, activities, materials, and staffing
- Information about program quality
- Tracking of program costs
- A descriptive base for program replication
- Attendance by each participant
- Program duration
- Degree to which participants were actively involved
- Cultural competence, responsiveness and appropriateness of the program
- A measure of satisfaction with the program and implementation
- Effectiveness of the program with the targeted population.

B. Outcome

Outcome evaluations focus on the extent to which a program's short- and long-term measurable goals and objectives have been met.

Outcome evaluation involves the following steps:

1. Establish program goals and outcome objectives.
2. Select or design a method to measure changes in objectives related to intervening variables. Both quantitative and qualitative methods can be used, and may include surveys, focus groups, interviews, observations and archival data. DBHS funded prevention programs are required to use a current DBHS State Outcome Measure (SOM) instrument to evaluate their program. SOM instruments are quantitative instruments. Where a SOM instrument is not applicable, RBHAs may request DBHS approval to use an alternative evaluation. When measures must be translated from English to another

language, care must be taken to be sure that both versions have equivalent meaning. In some cases, this will require changing the wording in English so that translation is possible. Prevention professionals need to always be cautious about the literacy of the participants. Reading the measures aloud while participants read to themselves and provide answers is a useful strategy to avoid embarrassing situations and random responding by those who cannot read.

3. Collect data
4. Organize the data in a database
5. Analyze and summarize results
6. Interpret findings from the process and outcome evaluations
7. Use findings to make improvements to the program

C. Improvement of Program Quality

The Strategic Prevention Framework includes a feedback loop to provide quality improvement both during program implementation and following outcome evaluation. The results of both process and outcome evaluation should be used to make ongoing changes and improvement.

Program improvement should focus on answering the following questions:

1. What program components worked well and should be continued in future implementation?
2. What program components did not work well and could/should be improved?
3. Were there components that did not work well for specific populations?
4. How can staff increase their effectiveness in implementing the program and working with participants?
5. Do results show the program makes a difference?

6. Sustainability and Cultural Competence

The SPF places sustainability and cultural competence at its center as these key concepts must be incorporated in every step. Both should be incorporated from the earliest stages of assessment through evaluation.

A. Sustainability

Effective prevention services take place at the community level and involve collaboration among community agencies, institutions and organizations. Community prevention coalitions promote sustainable prevention systems by developing leaders and building support of prevention efforts as they demonstrate that meaningful changes are taking place. Prevention programs should provide ongoing support that will enable communities not only to reach desired outcomes, but also to sustain them. This process must involve continual engagement with community stakeholders to ensure that efforts are on target with reaching desired goals and objectives. Effective prevention programs build on the capacity of communities to effect

community change, through identifying and empowering stakeholders to reach target audiences and implement chosen initiatives. Without a sustainable process that engages community leaders and key stakeholders, prevention efforts will not be able to respond effectively to the changing patterns of substance abuse behaviors and related problems.

Sustainability is fundamental to each step of the SPF process (Assessment, Capacity, Planning, Implementation, and Evaluation) and depends largely on community partnerships and coalitions strategically responding to the primary substance abuse problem affecting the community. It is very important that providers and communities all understand and support the prevention plan. The continual development of a community's ability to respond to its changing patterns of substance abuse and related consequences promotes sustainability of prevention efforts (SAMHSA, 2008). Sustainable programs leverage funds from multiple sources.

B. Cultural Competence

As the lens through which people view their world, culture is an important element of the design and implementation of prevention programs. Culture represents the shared values, norms, traditions, arts, history, folklore, music, religion, and institutions of a group of people. It also includes age, gender, and sexual orientation.

Effective prevention initiatives are grounded in the culture of the community. They include the targeted population in the assessment of the community, strategic planning, implementation, and evaluation. They thoughtfully consider the needs of their target population, while at the same time celebrating the diversity and culture found in these communities. Prevention strategies are based on the developmental stage of the target audience, have clear objectives, and provide good staff training.

Educational materials are available in the preferred language of participants and include examples pertaining to participants' culture. Any curricula used are culturally appropriate and responsive to participants.

Hiring prevention staff from the targeted community establishes credibility and trust with the population served (Roosa et al., 2002). Participants become more engaged in the program when they perceive that program staff members understand and care about them, their families, their community, and their issues (Trimble et al., 2001).

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (*CLAS) STANDARDS 1-14*

1. Health care organizations should ensure that patient/consumers receive from all staff members' effective, understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
3. Health care organization should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with Limited English Proficiency (LEP) at all points of contact, in a timely manner during all hours of operations.
5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing offers and written notices informing them of their right to receive language assistance services.
6. Health care organizations must assure the competence of language assistance provided to LEP patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
7. Health care organizations must make available easily understood patient related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the services.
8. Health care organizations should develop, implement and promote a written strategic plan that outlines clear goals, policies, operational plans and management accountability and oversight mechanisms to provide culturally and linguistically appropriate standards.
9. Health care organizations should conduct initial and ongoing organizational self assessment of CLAS related activities and are encouraged to integrate cultural and linguistic competence related measures into their internal audits, performance improvement programs, patient satisfaction assessments and outcomes.
10. Health care organizations should ensure that data on the individual patients'/consumers' race, ethnicity and spoken and written languages are collected in health records, integrated into the organization's management information systems and periodically updated.
11. Health care organizations should maintain a current demographic, cultural and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS related standards.
13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross cultural conflicts or complaints by patients/consumers.
14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS Standards and to provide public notice in their communications about the availability of this information.

RISK AND PROTECTIVE FACTORS

1. Risk Factors

A. Community

Socio-economic deprivation

The stress that poverty places on individuals and families correlates with the onset of behavioral health problems (Agerbo, Nordentoft, and Mortenson, 2002; Hansen, Giles, and Fearnow-Kenney, 2000; Hawkins, Catalano, and Miller, 1992; Kumpfer, 1999; Romer, 2003; White and Jodoin, 2004; Zaslow, Caulkins, and Halle, 2000).

Community disorganization

Communities with high population density, limited employment opportunities, high crime, physical deterioration, and low neighborhood cohesion, contribute to greater risks for social and behavioral health problems (Agerbo et al., 2002; 1999; Hansen, et al., 2000, Romer, 2003; Hawkins, et al., 1992).

Discrimination and devaluation

Discrimination and devaluation in American society, differing levels of assimilation, cultural or language barriers to receiving services, or unfavorable expectations from society, correlate with the development of behavioral health problems (Fashola and Slavin, 2002, Rutter and Soucar, 2002).

Availability of ATODs

Rates of substance use are higher in communities where alcohol and other drugs are inexpensive, easily available and acceptable (Hawkins, et al., 1992).

Mobility

Communities with high rates of resident mobility are at greater risk for crime and substance use (Bollinger, 2003).

B. Families

Family conflict and violence

Marital discord, domestic violence, conflict between caregivers and dependants, and divorce are risk factors (Bollinger, 2003; Hawkins, et al., 1992).

Attachment and bonding

Lack of closeness is correlated with onset of behavioral health problems (Guo, Hill, Hawkins, Catalano, and Abbott, 2002, Hawkins, et al., 1992).

Parental absence

Absence from a parent due to separation, divorce, incarceration, or death is a risk factor for the development of behavioral health problems in youth (Bethea, 1999; Romer, 2003).

Family attitudes favor substance use

Family use of and permissive attitudes toward substance use are correlated with substance use (Hansen, et al., 2000).

Family management problems

Lack of knowledge about how to care for dependants and unrealistic expectations are risk factors for abuse, neglect and substance abuse. Disciplinary practices that are overly permissive, inconsistent or severe are correlated with behavioral health problems (Kumpfer, 1999; Mihalic, Fagan, Irwin, Ballard, and Elliott, 2004).

Caregiver behavioral health problems

Youth are more likely to engage in problem behaviors when their parents or caregivers use substances (White and Jodoin, 2004; Hansen, et al., 2000; Hawkins, et al., 1992; Masten et al., 2008).

Abuse, neglect, or rejection

Abuse, neglect, and rejection by caretakers are risk factors for substance abuse, suicide, and other behavioral health problems (Bethea, 1999; Winters, August, and Leitten, 2003; Kumpfer, 1999; Hawkins, et al., 1992; Hansen, et al., 2000)

C. Institutional

Low expectations

Teacher expectations correlate with youth academic performance. Teachers treat students differently when they believe those students to be unintelligent or troubled (Brounstein and Zweig, 1999; Mihalic, et al., 2004).

Lack of opportunities for social interaction

School, work, and care home environments contribute to risk when the people in those environments lack opportunities for social interaction (Lackney, 1990).

Poor discipline

Overly permissive, authoritarian, and inconsistent disciplinary practices in schools create environments in which youth are more likely to engage in problem behaviors (Brounstein and Zweig, 1999).

Lack of comfort

School, work, and care home environments are a risk factor when the people in those environments are uncomfortable, lack privacy, are overcrowded, have loud noise or poor air flow (Lackney, 1990).

D. Relationships

Perceived isolation

A perceived lack of social support is a risk factor for depression, substance abuse and suicide (Blow, 2002; Newcomb and Felix-Ortiz, 1992).

Social failure

Shy or aggressive youth who are rejected by peers are at risk to develop behavioral health problems (Brounstein and Zweig, 1999; Winters, et al., 2003; Kumpfer, 1999; Hawkins, et al., 1992; Hansen, et al., 2000; Zaslow, at al., 2000).

Friends/partners who use substances or engage in other problem behavior

Having friends who use substances is one of the strongest predictors of substance use in youth. Youth who experience the suicide of a peer are more likely to attempt suicide. (Hawkins, et al., 1992; Aber, 2003; Winters, et al., 2003; Kumpfer, 1999; Hansen, et al., 2000; Zaslow, et al. 2000; White and Jodoin, 2004)

Loss of relationship

Adults who experience the death or divorce of a spouse, or a child leaving home are at greater risk for suicide (Rutter, 2002; Gliatto and Raj, 1999; Agerbo, et al., 2002).

E. Individual

Aggression

Aggressive children are more likely to engage in substance abuse and other negative behaviors. (Masten et al, 2008; Romer, 2003; Hawkins, et al., 1992; Catalano, Berglund, Lanzak, and Hawkins, 2002; Bollinger, 2003).

Early use of substances

The younger a person is when initiating use of alcohol and other drugs, the greater their chance of developing an addiction (Masten, Faden, Zucker, and Spear, 2008).

Anti-social behavior, attitudes and beliefs

Alienation from the societal values, dishonesty, and rebelliousness predict substance abuse, school drop out, suicide and delinquency particularly for boys (Irving and Barbara Gutin Charitable Family Foundation; Masten et al., 2008; Aber, Brown, and Jones, 2003)

Low commitment to school

Youth are more likely to engage in harmful behaviors such as substance abuse when they do not feel committed to school (Hansen, et al. 2000; Kumpfer, 1999).

Academic problems

Academic failure during childhood is predictive of later adolescent and adult behavioral health problems (Masten, et al, 2008; Hansen, et al., 2000).

Transitions

Changes in school or employment, retirement, death of a spouse, and menopause are times of stress (Robertson, David, and Rao, 2003; Zaslow, et al., 2000).

Coping skills

Stress combined with poor coping skills is a risk factor for suicide, substance abuse, and perpetration of abuse or neglect against children and/or elders (Bethea, 1999; White and Jodoin, 2004; Hansen, et al., 2000).

Self esteem

Low self esteem, internalization, self dislike, and self criticism are risk factors for perpetration of abuse and neglect, suicide and suicidal ideation (Rutter, 2002).

Perceived harm
People are more likely to use alcohol or other drugs when they perceieve the harm to self to be negligible (Hawkins, et al., 1992; Blow, 2002; Masten et al, 2008).

Changes in physical health, chronic illness, and pain
Poor physical health and physical disabilities are risk factors for abuse neglect, substance abuse, depression, and suicide (Blow, 2002; Kidd, 2002;).

Genetic factors and temperament
Sensation seeking, rumination, pessimism, anti-social behavior, high tolerance of deviance, resistance to authority, hyperactivity, and irritability are all correlated with development of substance abuse and other behavioral health problems (Hawkins, et al. 1992; Catalano, et al., 2002; Romer, 2003).

Cognitive learning difficulties and attention problems
Youth who experience trouble in learning or regulating their attention are at greater risk for addiction to alcohol (Masten et al., 2008).

Prenatal exposure to substances
Substance use during pregnancy and infancy predisposes children to later aggressive behavior, substance abuse and suicide (Masten et al, 2008; Mihalic, et al. 2004; Bollinger, 2003).

Impulsiveness and rebelliousness
People who are impulsive, rebellious, hostile and/or lack inhibition are more likely to engage in dangerous risk taking behaviors such as substance use, violence, or suicide (Masten et al, 2008; Robertson, et al., 2003; White and Jodoin, 2004).

Belief in traditional gender roles
Men who believe strongly in traditional gender roles are more likely to complete suicide. Traditional gender role is defined as values of success, power, and competition, restricted affection between men, and restrictions on expressing emotions (Irving and Barbara Gutin Foundation Charitable Family Foundation).

2. Protective Factors

Protective factors are personality, family, and environmental buffers that help people to thrive despite risky environments. Prevention programs seek to bolster people, families, and communities' strengths and innate capacity for learning and success by building on strengths.

A. Community

Opportunities for meaningful citizen participation and community service
When community members have opportunities to become involved in their community and make positive change, they take ownership of and pride in the community (Catalano, et al., 2002; White and Jodoin, 2004; Kumpfer, 1999).

Access to community resources

Easy access to quality health care, social services and other community resources such as housing, child care, employment, and recreation are conditions that protect people from developing behavioral health problems (Kumpfer, 1999).

B. Family

Secure attachment

Bonding and secure attachment between caregiver and child is crucial to healthy development and prevention of abuse and neglect (Thomas, et al., 2003; Catalano, et al., 2002; Romer, 2003; Hawkins, et al., 1992; Mihalic, et al., 2004).

Authoritative parenting

Families in which consistent non violent discipline is used and limits are set on behavior are more protective for youth (Kumpfer, 1999; Kumpfer, 1999;; Hansen, et al. 2000; Romer, 2003 Zaslow, et al. 2000).

Belonging

The perception that one has a family (natural or not) to which one belongs and in which one can find acceptance and emotional support is a protective factor for all persons (Catalano, et al., 2002; Brook, Zheng, Whiteman, and Brook, 2001; Hawkins, 1992; Romer, 2003).

Traditional cultural values

Families, which have strong cultural traditions and values, are more protective for youth (White and Jodoin, 2004).

Family support

Family support and encouragement correlates with better school performance and avoidance of behavioral health problems (Kumpfer, 1999; Romer, 2003).

Caregiver monitoring and supervision

Children are less likely to engage in harmful or dangerous behaviors when their caregiver knows where they are and what they are doing. Children perform better in school when caregivers monitor homework and television viewing (Hansen, et al., 2000; Zaslow, et al., 2000; Sale, Sambrano, Springer, and Turner, 2003)

C. Institutional

Opportunities for success

Schools that promote the mental health of children, focus on mastery of material, and give children opportunities to experience success are more protective (Hansen et al, 2000).

Challenge with support

People excel in environments in which they are challenged to perform and provided the tools and support to be successful in their activities (Hansen et al., 2000).

Caring relationships
Institutions, in which staff members demonstrate caring through support, respect, and compassion, have more successful members (Hansen et al., 2000).

Opportunities for involvement
When people have opportunities to actively participate in the formation of policy in a school, religious setting, or care home, people develop a stronger relationship with the institution (Sale, Sambrano, Springer, and Turner, 2003).

Safety
People in institutional environments are more likely to engage in healthy behaviors when they feel safe (Lackney, 1990).

Expectations
Belief in people's innate intelligence, resiliency, talent and capacity for success is correlated with success. This concept is related to working from a strengths based perspective (Brounstein and Zweig, 1999; Hansen et al., 2000).

Interactive learning
Providing youth with opportunities to engage in collaborative and cooperative learning is a well-documented approach to improving youth success in school (Hansen, et al, 2000).

D. Individual

Empathy
Empathic people are less likely to engage in violence. They are more likely to relate to the needs of dependants, and therefore, less likely to abuse or neglect (Hansen, et al., 2000).

Problem solving skills
The ability to generate alternative solutions to problems is correlated with resiliency (Brounstein and Zweig, 1999).

School success
Successful school performance is correlated with healthy behavioral outcomes (Robertson, 2003; Romer, 2003; Brounstein and Zweig, 1999).

Physical health
Overall good physical health is a protective factor (Brounstein and Zweig, 1999, White and Jodoin, 2004; Zaslow, et al., 2000)

Self-efficacy
People with a sense of control and confidence in themselves and their ability to make decisions are less likely to engage in harmful behaviors (Zaslow, Caulkins, and Halle, 2000; Mihalic, et al., 2004; Catalano, et al. 2002).

Temperament
Temperament is related to how people respond to stress and change as well as how they seek stimulation. People who are optimistic and hopeful that problems may be overcome are more resilient to the development of behavioral health problems (Mihalic, et al., 2004; Hawkins, et al., 1992).

Cultural Pride
The combination of knowledge, pride, and belonging to a cultural group moderates the effects of discrimination (Kumpfer, 1999; Kulis, Napoli, and Marsiglia, 2002; Marsiglia, Kulis, and Hecht, 2001; Miller, 1999).

Autonomy
The ability to be your own person and make age appropriate decisions is essential to behavioral health (Hansen, et al., 2000; Mihalic, et al., 2004)

Sense of future/purpose
Individuals who have a plan for the future, sense of hope, and/or purpose are less likely to engage in negative behaviors (White and Jodoin, 2004; Hansen, et al., 2000).

Social competence
Children with good social skills are more likely to make friends and get social support (Zaslow, et al. 2000; Catalano, et al., 2002; Hansen, et al., 2000).

Religion/spirituality
Active participation in a religious institution is correlated with positive behavioral health (Bollinger, 2003; Romer, 2003).

School connectedness
Youth who enjoy going to school are more likely to have positive behavioral health outcomes (Hawkins, et al., 1992; Newcomb, 1992).

Coping skills
Coping skills (flexibility, the ability to adapt, recognition of danger, ability to imagine the future, help seeking behavior, and capacity to deal with stress) correlate with positive behavioral health outcomes (Irving and Barbara Gutin Charitable Family Foundation. Catalano, et al., 2002).

E. Relationship

Bonding to peers
Having a relationship with peers who engage in healthy behaviors is a protective factor. When peers engage in pro-social behavior, children are also more likely to do so (Thomas, et al., 2003;).

Bonding to an adult
The development of warm, supportive relationships and bonds to positive adults during childhood inhibits substance abuse. (Kumpfer, 1999; White and Jodoin, 2004).

GLOSSARY

Tribal and Regional Behavioral Health Authorities and their sub contractors may not redefine any of the terms below without the express written consent of the Division of Behavioral Health Services

Accountability	Demonstrating a program achieves its targeted outcomes and uses resources effectively.
ADHS	Arizona Department of Health Services
ARS	Arizona Revised Statutes. The laws of the State of Arizona.
ATOD	Alcohol, tobacco, and other drugs
Capacity building	Developing organizational resources, infrastructure, support, and funding that will be needed for successful implementation of selected strategies, approaches and programs.
Causal Factor	A determining or causal element or factor
Coalition	An alliance among individuals collaborating to promote the health and wellness of a community.
Community development	The creation of conditions that promote the well being of an entire community.
CSAP	Center for Substance Abuse Prevention
Cultural competence	A set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals which enables that system, agency or those professionals to work effectively in cross cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religions, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by behavioral health recipients and their communities.
Cultural group	People who share values, norms, symbols, and ways of living that are repeated from one generation to another.
Culturally based	Developed in collaboration with or by the targeted population for the targeted population.
Culture	The characteristics in addition to race, language, and ethnicity that contributes to a person's sense of self in relation to others. A person may identify him or herself according to general subgroups (such as age, gender, sexual orientation or gender orientation) or shared life experience (such as survival of violence and/or trauma, disability status, education, occupation, socio-economic status, or homelessness.) Multiple memberships in these subgroups contribute to an individual's personal identity and sense of own "culture". Understanding how these factors influence the way a person seeks and uses behavioral health services is important to providing culturally competent care.
Curriculum	A written document which details the workshops, lessons, and/or presentations used in life skills education, parent education, community education, and/or training services.
DBHS	Division of Behavioral Health Services. A Division of the Arizona Department of Health Services.
DBHS prevention network	Providers and programs that receive funds from DBHS via the Regional Behavioral Health Authority.

Diversity	A condition in which members of a community have differences in race, ethnicity, language, gender, sexual orientation, or religion.
Duplication	Paying for the same item and charging for that one same item twice to two different funding sources. Also commencing a similar program in competition with an existing program.
Environmental strategy	Activities designed to modify systems in order to mainstream prevention through formal and informal policies and law.
Evaluation	Collection and use of program information for monitoring, program improvement, outcome assessment, planning, and policy-making.
Evidence Based Practice	Evidence-based Strategies are those which: -Appear on a Federal list. -Appear in a peer-reviewed journal as effective. -Demonstrate "documented effectiveness" and are so designated through a consensus of experts.
Goal	A broad statement describing the desired impact or outcome of a specific program.
Impact	Long-term, overall effects of a program or intervention such as changes in behaviors or conditions.
Indicated	Prevention efforts targeting a population that is just beginning to engage in a problem behavior.
Key informant	A person with the background, knowledge, or skills needed to contribute information relevant to a community needs assessment.
Leveraging funds	Using funds from two or more different sources to support a prevention program.
Logic model	A chart that shows how the logical connections between the problems and/or needs relate to the actions taken to achieve the goals.
Matching funds	Funds from one source which are leveraged to secure/retain funds for the same project from a second fund source.
May	Indicates something that is not mandatory, but permissible. Same as should.
Monitoring	Tracking services and structures that a program is accountable for accomplishing and/or maintaining to ensure that the program is being implemented as planned.
Must	Indicates a mandatory requirement.
Needs and resource assessment	Gathering information about current conditions within a community that underlie the need for preventative interventions. Researching the existing structures, programs, and other activities potentially available to assist in addressing identified needs.
Normative education	Information regarding the actual numbers of persons who use substances and acceptability of use.
Objectives	Measurable statements of the anticipated change in risk or protective factors.
Older adult	A person who is age 55 or older.
Outcome	The immediate desired change in attitudes, values, behaviors, or conditions. Stated in the following format: "By a specified date, there will be a change (increase or decrease) in the target behavior, among the target population."
Pre-post test	Evaluation instruments that assess change by comparing the baseline measurement taken before a program begins to measurements taken after a program has ended.
Prevention	1) The creation of conditions, opportunities, and experiences that encourage and develop healthy, self sufficient children and that occur before the onset of problems (Arizona Revised Statutes). 2) Prevention is an active process that creates and rewards conditions that lead to healthy behaviors and life styles (CSAP).
Primary prevention	Strategies designed to decrease the number of new cases of a disorder or illness.
Process evaluation	Assessment of activities implemented, quality of implementation, participant demographics, quality of participation, dosage, resources, staffing, and other

	factors. A process evaluation describes the inputs to program delivery, documents what programs actually do, and describes how implementation effectiveness is determined.
Program	A set of prevention strategies, which address a common set of goals and objectives for a common target audience in one county.
Protective factor	An attribute, situation, condition, or environmental context that develops resiliency in individuals and prevents the likelihood of ATOD use.
Provider	An organization that provides prevention services directly.
RBHA	Regional Behavioral Health Authority.
Recurring/direct program participant	A person who is part of an ongoing prevention effort, whether that is a parenting class, a neighborhood coalition or a life skills group, etc.
Resilience	The personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, and other stresses and to go on with life with a sense of mastery, competence, and hope (New Freedom Commission on Mental Health, 2003).
RFP	Request for Proposals
Risk factor	An attribute, situation, condition, or environmental context that increases the likelihood of ATOD use or abuse or other behavioral health problems.
SAMHSA	Substance Abuse and Mental Health Services Administration
Selective	Prevention efforts targeting individuals whose risk of developing ATOD problems or engaging in other problem behaviors is higher than average.
Shall	Indicates a mandatory requirement.
Should	Indicates that something is recommended, but not mandatory. Same as may.
Single program participant	Someone just "passing through," at a health fair or who once or twice attends a community meeting, etc.
Social indicator	Measures of the prevalence of protective and risk factors and social problems based on archival data from records collected and kept by agencies.
Stakeholder	Any individual or organization with interest or investment in a project and/or its evaluation.
Strategic Prevention Framework	A community-based approach to prevention. The SPF uses a step-by-step process to help communities identify, manage, and evaluate their substance abuse prevention and mental health needs.
Strategies	Specific, research-based approaches for achieving project objectives.
Sustainability	Using funds from multiple funders, so that program continuation is not reliant on one sole fund source.
Target population	The group of individuals for whom a prevention program is designed and intended to have an impact.
TRBHA	Tribal Regional Behavioral Health Authority.
Tribal contractor	A Tribal Nation that provides direct behavioral health services via an Intergovernmental Agreement (IGA) with DBHS.
Unduplicated	The number of people served at least once with each person counted only once.
Universal	Prevention efforts targeted to a population that has not been identified on the basis of individual risk.

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